TESTIMONY

OF

CARDINAL BERNARD LAW

Archbishop of Boston

ON BEHALF OF

COMMITTEE FOR PRO-LIFE ACTIVITIES

NATIONAL CONFERENCE OF CATHOLIC BISHOPS

Hearing on Ethical, Legal and Social Issues in Assisted Suicide

House Commerce Subcommittee on Health and Environment

March 6, 1997

I am Cardinal Bernard Law, Archbishop of Boston and Chairman of the National Conference of Catholic Bishops' Committee for Pro-Life Activities. I want to thank this Committee for giving the Catholic bishops of the United States this opportunity to urge Congress to oppose physician-assisted suicide.

I. A Question of Compassion

It is increasingly evident that the value of human life is at stake in our society. Recent revelations concerning the use of deception to defend partial-birth abortion have shocked the nation. Deception and misinformation also arise on the issue of physician-assisted suicide. Euthanasia groups have portrayed a natural death as necessarily painful, undignified, costly and humiliating, as a not-too-subtle inducement to accept suicide and assisted suicide. Such stereotypes have even been endorsed in chilling decisions by the Second and Ninth Circuit Courts of Appeals, which are under review by the U.S. Supreme Court. The rich and hallowed virtue of *compassion* is drained of meaning when it is invoked as a basis for destroying human life.

By and large, seriously ill patients do not want assisted suicide. They want decent health care, control of their pain, and the same kind of love and support that everyone needs when vulnerable and dependent on others.

While dying of cancer last November, my friend and my brother bishop, Cardinal Joseph Bernardin, provided an authentic voice of experience on this issue. He took the time during his last weeks of life to write to the Supreme Court about the cases on assisted suicide under its review. Cardinal Bernardin wrote:

I am at the end of my earthly life. There is much that I have contemplated these last few months of my illness, but as one who is dying I have especially come to appreciate the gift of life. I know

from my own experience that patients often face difficult and deeply personal decisions about their care. However, I also know that even a person who decides to forego treatment does not necessarily choose death. Rather, he chooses life without the burden of disproportionate medical intervention.

Pointing out that legalizing assisted suicide would endanger vulnerable people and corrupt the patient-physician relationship, he continued:

There can be no such thing as a "right to assisted suicide" because there can be no legal and moral order which tolerates the killing of innocent human life, even if the agent of death is self-administered. Creating a new "right" to assisted-suicide will endanger society and send a false signal that a less than "perfect" life is not worth living.

Cardinal Bernardin knew what so many who have confronted terminal illness have also learned: The final months of life are no less precious than any other time, but offer unique opportunities for love, community and personal growth -- for the patient, and all who share the patient's journey.

No one of us is without our most intimate experiences of death. On Sunday, November 24, 1991, my mother died in St. Elizabeth's Medical Center in Boston. Her death came after a very lengthy illness. Her condition, in fact, was the same as that of one of the plaintiffs in the pending Ninth Circuit case. She had emphysema and congestive heart failure.

Thank God, my mother lived far beyond her life expectancy, with the help of excellent medical care. While she was not immune to the inevitable periods of depression often associated with a debilitating illness, she loved life and she was loved until her death. Her last moments on earth were without pain, she was conscious until almost the end, and she was surrounded by love. That, I submit, is what compassion in dying is all about.

II. A Question of Justice

Supporters claim that assisted suicide is about promoting "freedom of choice" and relieving suffering for terminally ill people. Yet people who may want to commit suicide are found in every demographic group -- especially among the young, the very old and members of high-stress professions. Suicidal desires among the terminally ill are no more "free," and no less caused by treatable depression, than those felt by other people. Yet an entire political movement has dedicated itself to facilitating suicide for the seriously ill, even while the law rightly continues to forbid this destructive "choice" for everyone else.

By selectively legalizing assisted suicide for a certain class of people, a state makes its own supposedly "objective" judgment that these people, unlike any others, merit suicide. When people in this class think they have lives not worth living, a government that condones assisted suicide sends the message that it can think of no reason to disagree.

This flies in the face of the convictions held by most people in the very class supposedly "benefited" by assisted suicide. For all the evidence indicates that elderly, seriously ill and disabled people are much more *against* the "choice" of assisted suicide than younger, more able-bodied Americans are.[1]

---

[1]A recent *Washington Post* poll found that voters aged 35-44 favored legalizing physician-assisted suicide 57% to 33%, but voters aged 65 and older opposed it 54% to 38% (*Washington Post*, 4/ 4/96, p. A18). Terminally ill cancer patients experiencing significant pain are more opposed to assisted suicide than other cancer patients or the general public; the patients who favor assisted suicide tend to be those with clinical depression (Dr. E. Emanuel *et al.*, "Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public," 347 *The Lancet* 1805 (June 29, 1996) at 1809). Frail elderly patients receiving outpatient care strongly oppose physician-assisted suicide, with only 34% favoring legalization; but 56% of their younger relatives favor it, and are often wrong in predicting the patients' views (Dr. H. Koenig *et al.*, "Attitudes of Elderly Patients and their Families Toward Physician-Assisted Suicide," 156 *Archives of Internal Medicine* 2240 (Oct. 28, 1996)).

In this context we agree with the 1995 ruling by U.S. District Court Judge Michael Hogan, who found that Oregon's law selectively allowing assistance in suicide for patients diagnosed as terminally ill violates constitutional guarantees of equal protection under law. Under a law like Oregon's Measure 16, the great majority of citizens continue to be legally protected from anyone who wants to encourage and assist their suicides. This able-bodied majority, however, has voted to change the law so that those expected to have less than six months to live are treated in just the *opposite* way, with the law arranging for physicians to help them kill themselves. As Judge Hogan said in his opinion:

> Measure 16 withholds from terminally ill citizens the same protections from suicide the majority enjoys. In the process, it has lowered standards and reduced protections to a degree that there is little assurance that only competent terminally ill persons will voluntarily die. The majority has not accepted this situation for themselves, and there is no rational basis for imposing it on the terminally ill.[2]

Congress has a responsibility to study this threat to equal justice under law, as well as other ways in which legalization of assisted suicide in one state may implicate and even conflict with longstanding federal laws.[3] A pure "states' rights" stand is inappropriate when action by one state threatens the basic rights of a class of people and undermines the moral fabric of a society. "States' rights" has its limits when the issue is racial justice, religious freedom, or the integrity of marriage. It also reaches its limit when a state policy excludes vulnerable people from protection for their very lives.

---

[2]*Lee v. Oregon*, 891 F.Supp. 1429, 1438 (D. Or. 1995), *rev'd on jurisdictional grounds*, No. 95-35804, 1997 WL 80783 (9th Cir. Feb. 27, 1997).

[3]See the Appendix to this testimony on federal issues raised by a state's decision to legalize assisted suicide.

III. **Preventing Federal Support for Assisted Suicide**

Quite aside from the ultimate legal or constitutional status of assisted suicide, Congress has an immediate problem involving the integrity of its own federally funded health programs. This problem arises from the anticipated legalization of physician-assisted suicide in Oregon through Measure 16, and the prospect that upon legalization the state may include the prescribing of lethal drugs in its Medicaid plan. Legislation like the Assisted Suicide Funding Restriction Act[4] is urgently necessary for three reasons:

1. Maintaining the Integrity of Health Programs. An immediate problem for Congress's attention is the imposition placed upon Catholic and other taxpayers of 49 states if Oregon or any other state begins to incorporate assisted suicide into programs such as Medicaid.[5] Federal health programs are designed to support and enhance life, not to destroy it. Simply to maintain the integrity of its own programs, Congress should enact the Assisted Suicide Funding Restriction Act.

[4]Introduced in the 104th Congress as H.R. 4149 and S. 2108; re-introduced without substantive change in the 105th Congress as S. 304.

[5]See: D. Postrel, "State could cover assisted suicide," *Salem Statesman-Journal*, 12/6/94, p. A1 (citing state Medicaid director Jean Thorne); Associated Press, 11/11/94 (citing Oregon Health Services Commission chair Dr. Paul Kirk).

2. Preserving Vital Distinctions. A second reason to enact this bill is to clarify at a national level some important distinctions which are well-known in medical ethics, religious morality, and common sense -- distinctions between assisted suicide, on the one hand, and legitimate medical decisions to withdraw burdensome treatment or provide aggressive medication to control pain, on the other hand. Sadly, these basic distinctions are being blurred or rejected by some in our society, including some federal judges. Congress should make its view clear that prescribing lethal drugs for a patient's suicide is not any part of legitimate medical practice. It is one thing to kill pain, and quite another thing deliberately to kill one's patient.

Catholic morality teaches that life is our first and most basic gift from a loving God -- a gift over which we are called to have careful stewardship, not absolute dominion. This stewardship demands that we take reasonable steps to preserve human life. It does not obligate us to use every possible treatment to prolong life, regardless of the circumstances. However, it does reject all directly intended causing of death. The distinctions embodied in the Assisted Suicide Funding Restriction Act are consistent with this vision of careful stewardship over life.

3. Protecting Religious Freedom. Catholic opposition to euthanasia and assisted suicide is as old as Christianity.[6] In fact, moral teaching against assisting a suicide is older than Christianity, for it is found in Jewish tradition and in the Hippocratic Oath which laid the groundwork for modern medicine as a healing profession. Therefore it is cause for alarm that

[6]This fact deserves restating because a recent ruling by the Ninth Circuit Court of Appeals thoroughly distorts the historical record. The Catholic Church's constant teaching against homicide, suicide and assisted suicide is reaffirmed authoritatively in Pope John Paul's 1995 encyclical *Evangelium Vitae* (*The Gospel of Life*). For responsible accounts of the early Church's opposition to suicide and euthanasia, see: Darrel W. Amundsen, "Suicide and Early Christian Values," in *Medicine, Society, and Faith in the Ancient and Medieval Worlds* (Johns Hopkins University Press 1996), pp. 70-126; Thomas J. Marzen, "Assisted suicide: Back to the (pagan) future," *Our Sunday Visitor*, 4/14/96, pp. 6-7.

Oregon's new law on assisted suicide could interact with the federal Patient Self-Determination Act (42 USC §1395cc (f)) to require Catholic hospitals, hospices and nursing homes to counsel all patients upon admission on their "right" to assisted suicide. No law should try to force Catholic and other health care institutions to facilitate the killing of their patients.

Confronted with this threat to the First Amendment, the Ninth Circuit Court of Appeals recently acknowledged that the threat may be real -- but said that any problems arising from Measure 16's interaction with federal "informed consent" laws must be addressed by amending those laws, not by invalidating Measure 16.[7] The Assisted Suicide Funding Restriction Act would address this problem, by stating that assisted suicide is outside the scope of the *mandatory* counseling and referral that federal law requires in facilities receiving Medicaid and Medicare funds.

IV. Conclusion

There are alternative solutions to the problems which assisted suicide purports to solve -- solutions which do not demean human life or place pressure on helpless patients to end their lives. What Pope John Paul II has called "the way of love and true mercy"[8] -- easing suffering, keeping company with the dying, and affirming the dignity of their lives at every stage -- is the most complete response to efforts to promote death as a solution.

We hope that Congress, in the months to come, will prevent federal funding for assisted suicide. Congress should also explore ways to help make this practice unthinkable in our society, by protecting the equal dignity of all human life and promoting truly compassionate solutions for

---

[7] *Lee v. Oregon*, No. 95-35804, 1997 WL 80783, at *8 n. 6 (9th Cir. Feb. 27, 1997).

[8] *Evangelium Vitae*, op. cit., §67.

those who now lack adequate care when they are seriously ill. Thank you for your attention.

APPENDIX TO TESTIMONY OF CARDINAL BERNARD LAW

HOUSE COMMERCE SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

March 6, 1997

Physician-Assisted Suicide: A Federal Issue

Recent federal court rulings raise the issue of assisted suicide to a new level of national concern. The issue has serious implications for Congress. Even a law allowing physician-assisted suicide in one state such as Oregon raises several questions:

- **Federal funding**: When the nation's first and only statute allowing physician-assisted suicide was approved in Oregon in November 1994, the chairman of the state Health Services Commission announced that expenses connected with assisted suicide will be reimbursable in the state's Medicaid program [Associated Press, 11/11/94]. Lethal drugs will be covered as a form of "comfort care," which ranks as a high priority in the Medicaid rationing plan which Oregon operates under a waiver granted by the Clinton Administration. Many life-prolonging treatments for terminally ill patients rank very low on this cost-effectiveness scale and may not be available to indigent patients in the state; but lethal drugs will be offered to them free of charge. The issue of using federal funds and health facilities for assisted suicide will also arise in other federal programs: military hospitals, Medicare, Indian Health Service, federal employees' health benefits, and so on.

- **Civil Rights**: In a preliminary injunction against Oregon's new law, a U.S. District Court said questions have been raised as to whether a law selectively allowing assisted suicide for people with AIDS and other disabilities violates the federal Americans with Disabilities Act (42 USC §12101 et seq.). Supporters of assisted suicide argue that a person with AIDS simply receives an additional "benefit" from the Oregon law that is not available to other people. But why would a state treat as a "benefit" for this person something that remains a crime if performed on non-disabled persons? Doesn't such a policy treat the life of a person with disabilities as uniquely valueless? See *Lee v. Oregon*, 869 F. Supp. 1491, 1499 (D. Or. 1994).

- **Federal Drug Laws**: Implementation of a law allowing assisted suicide may require the prescribing of barbiturates and other drugs for the intentional taking of human life -- a purpose never approved by the Federal Food, Drug, and Cosmetic Act (21 USC §301 et seq.) or the Controlled Substances Act (21 USC §801 et seq.). Such use seems antithetical to these laws' stated purpose of protecting life and health. See G. Annas, "Death by Prescription: The Oregon Initiative," in *New England J. of Medicine*, 11/3/94, p. 1242.

- **Patient Self-Determination Act** (42 USC §1395cc (f)): As a condition for receiving Medicaid and Medicare funds, health care facilities in the United States must inform their patients upon admission regarding whatever rights they may have under state law to accept or refuse medical treatment. The Oregon case has raised the question whether this federal law will

automatically "kick in" and require hospitals, including Catholic hospitals, to counsel patients on their "right" to assisted suicide if a state has legalized this practice. See *Lee v. Oregon* at 1500.

- **Religious Freedom Restoration Act** (42 USC §2000bb et seq.): Under this federal law, a state may not substantially burden the exercise of religious freedom unless this is the most narrowly drawn means of serving a compelling state interest. A law like Oregon's places a grave burden on Catholic and other religious health facilities by, among other things, forbidding them to discipline physicians and other staff who violate the facilities' ethical codes against assisting a suicide. See *Lee v. Oregon* at 1500-02.

Secretariat for Pro-Life Activities
National Conference of Catholic Bishops
Washington, D.C.
(202) 541-3070